

School District No. 36 (Surrey)

FIELD STUDIES MEDICAL FORM
FOR OUTDOOR AND/OR OVERNIGHT AND/OR OUT OF PROVINCE

Name of Student _____ Grade _____ Division _____
 Care Card Personal Health No. _____ Date of Birth _____
 Family Doctor _____ Phone No. _____

Name of Parent/Guardian _____
 Address _____
 Home Phone _____ Business Phone _____ Cell Phone _____

In case of emergency contact Parents/or:
 Name _____ Phone No. _____

Please note any health problems, emotional difficulty, behaviour concerns, mental health concerns, or other factors which may limit full participation in this program. Use back of sheet if necessary.

Has the student had a previous injury which would require special first aid treatment should another injury occur? Explain. _____

The student has received the regular immunization program administered in B.C. for diphtheria, pertussis and tetanus (DPT); tetanus and diphtheria (Td); polio; measles, mumps & rubella (MMR). Yes No (Circle)

Contact Lenses Yes No (Circle)

Child is subject to:

- | | | | | |
|---------------------------------------|--|--|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ear ache | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> nosebleeds | <input type="checkbox"/> sinus problems |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> eye infection | <input type="checkbox"/> kidney problems | <input type="checkbox"/> pulled muscles | <input type="checkbox"/> sleep walking |
| <input type="checkbox"/> dislocations | <input type="checkbox"/> fainting | <input type="checkbox"/> mental health | <input type="checkbox"/> seizures | <input type="checkbox"/> sprains |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> headache | <input type="checkbox"/> motion sickness | <input type="checkbox"/> sensitive skin | <input type="checkbox"/> tonsillitis |
| | <input type="checkbox"/> nightmares | <input type="checkbox"/> severe allergies | <input type="checkbox"/> other | |

Please describe in detail any necessary information regarding the above medical problems: _____

Medications: All medicines should be clearly labelled with the child's name and information below. All medications must be controlled and in the possession of the first aider (except for allergies). Use back of form if additional space is needed to list medications.

Name of medicine _____ Used for _____

To be administered by _____ Quantity & Times _____

Permission granted by _____ Given how _____

In case of emergency, I hereby give permission to the physician selected by the educator-in-charge to provide necessary treatment for my child.

Parent/Guardian Signature _____ Date _____